

EDITORIALS

Of Gerontology, Geriatrics and Gereology

THE AVERAGE life expectancy at birth has been steadily increasing, as is well known. Medical science and better health care have played their parts at each stage of human life, as have improved sanitation, better nutrition, power-assisted human labor and much else. The human population at any given moment is the aggregate of the individual lives that are moving inexorably through a continuum of stages starting from conception in a mother's womb. In recent years both ends of the normal human life span have received special attention, and health care and quality of life, particularly in the later years, are becoming of increasing economic and humanitarian importance.

Shakespeare succinctly described seven stages of life. For our purposes, perhaps we can be satisfied with three. There is a period of growth and development before the prime of life. This is a time of physical and mental maturation and of steadily diminishing dependence on others. Then there is the prime of life, a time of maximum vigor and productivity and of minimal dependence on others. Then, if one lives long enough, there is eventually a third period beyond the prime, when vigor lessens and dependence on others usually increases. At both ends of the life span there is an unavoidable need for the help and support of those who are in the prime of life. As the number of persons living on into the later decades and past their prime increases, more attention is being given to the processes of aging, to the ailments that mar health and the quality of

life for older persons, and to the social, economic and political consequences of a growing population who have returned to dependency on others. It is suggested that *gerontology* is the study of the processes of aging, that *geriatrics* is concerned with the ailments that accompany growing older, and that *gereology* be used for the study of the social, economic and political consequences of a growing population who have passed their prime.

There is much to be done in each of these fields and there is some urgency because the average life expectancy is now approaching 80 years. It seems obvious for many reasons that the prime of life should be extended as far as possible toward the end of a life span. This will require attention to the processes of aging and to the role of a genetic and cultural heritage, as well as to nutrition and life-styles, and to growth in useful experience and wisdom to offset the loss of energy (which some might call an inevitable increase in the entropy of the organism) that takes place with each passing year. Also, as one ages, one collects scars from the traumas of illness, injury or emotional disturbance; when these wounds do not heal, the burden of impaired health is carried on into later years. It is this residual from earlier life experiences that, together with the special health hazards of the later years, makes up the subject matter of geriatrics and separates it from gerontology. And then there are the human or humanitarian needs of persons who are beyond their prime and the social, economic, political and

even ethical impact that these needs have and will have on friends, family and society as a whole. This constitutes yet a third area of concern, the burden of which is a personal or public responsibility which falls mostly on those yet in their prime. This is a distinct dimension of the problems of an older population, which could well become the subject matter of gerontology.

It seems clear that the aim of gerontology, geriatrics and gerontology should be to gain a better understanding of aging beyond the prime and, more particularly, how to extend this middle stage of life for as many years as possible to avoid, postpone or diminish the dependency upon others which so often characterizes the lives of those who are past their prime. The burgeoning of this segment of the population makes the goal a matter of no small importance and no little urgency.

—MSMW

Psychotherapeutic Drugs in Medical Practice

THE ARTICLE "Psychopharmacology in Medical Practice" by Robert Sack and James Shore in this issue raises several questions that need elaboration: Are psychotherapeutic drugs overused by primary care physicians? Are drugs used in a medical model with a definite diagnosis in mind? How can the risks of treatment be minimized? How can these drugs best be used in mental disorders associated with physical illnesses?

The majority of psychotherapeutic drugs, especially the widely used antianxiety-hypnotic and antidepressant drugs, are most often prescribed by nonpsychiatric physicians. The usual estimate is that 70 percent to 80 percent of these drugs are prescribed by physicians other than psychiatrists. Allegations that these drugs are overprescribed are generally directed toward primary care physicians.

This question is most often raised about antianxiety drugs. Approximately one adult in six receives these drugs during the course of a year. However, only 1 in 16 takes these drugs for more

than a month. These figures are rather constant among different countries of Western Europe as well as for the United States.¹ Considering the vast differences in social, political, economic and cultural conditions among the various countries, it seems remarkable that the range of such use is so narrow. One might speculate that a small portion of the population may require antianxiety drugs to handle stress-induced anxiety, but that the majority of stressed persons do not need drugs. About three out of four of those who use these drugs receive "substantial benefit."

The issue ultimately becomes philosophical. If one believes that drug therapy complements problem-solving procedures, be they called psychotherapy or whatever, then limited use of antianxiety drugs makes good sense. If one believes that drugs offer an easy way out, leading to avoidance of problem-solving, then any use is bad. For many physicians, as well as patients, judicious use of antianxiety drugs may be the most expedient and cost-effective way to manage emotional disability.

On the other hand, underuse of antidepressants may be the case. Too few patients are treated with these drugs, largely due to difficulties in making the diagnosis. Depression can easily be missed or the confusing array of somatic symptoms ascribed to a variety of physical illnesses. As anxiety is an inevitable accompaniment of depression, patients may be inappropriately treated with an antianxiety drug.

Another criticism is that antidepressants are often used in too small a dose or for too short a time. Many failures of antidepressants have been linked to insufficient treatment. The hope that monitoring plasma concentrations of tricyclic antidepressants might lead to a better clinical outcome has only been partially realized. One can detect the seriously under-treated patient and remedy that situation, however.²

The second issue raised by Drs. Sack and Shore concerns the difficulties of psychiatric diagnosis. While it is the goal of all medical practice to let diagnosis dictate treatment, psychiatric diagnosis remains primitive. Compared with the vast array of new diagnostic tests and procedures available to other branches of medical practice, psychiatric diagnosis today is not different from that of 30 years ago. Diagnoses are still based fundamentally on *soft* clinical data. The constellation of clinical

A Medical Progress article "Psychopharmacology in Medical Practice" appears elsewhere in this issue.